Voices of the Unheard

Testimonies from the People's Health Assembly

December 2000

Dhaka

Bangladesh

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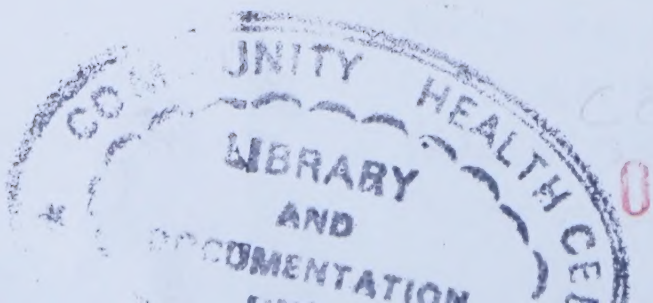

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Introduction

Every year in Geneva, Switzerland, health decision-makers from all over the world attend the World Health Assembly, the governing body of the United Nations' World Health Organisation (WHO). Over the years, non-governmental organisations have lobbied for people-sensitive health policies at the World Health Assembly, but to little avail. Thus they envisaged a People's Health Assembly as both a forum and process that would enable people to be involved in making decisions which affect their health and their lives.

In December 2000, more than 1,500 people from over 90 countries gathered in Bangladesh just outside its capital, Dhaka, for the first People's Health Assembly. They were people involved not just in health but also development, human rights, agriculture, trade, economics and the environment. Over one-third of participants were grassroots workers — village-level health workers, traditional midwives, health activists and community leaders.

At the five-day Assembly, there were many rousing speeches, analytical presentations and in-depth workshops. But one of the main inputs was the sharing of people's stories and testimonies of their lived experiences with health-related problems and concerns in their lives and communities. People spoke out clearly, directly and movingly, "demonstrating the power of witness, of speaking out with one's own voice and mind, with integrity and truth", said James Orbinski from Medicins Sans Frontieres. They demanded better health, justice, peace and equity. They reaffirmed their rights and responsibilities to be involved in the decisions that affect their lives and their health. They confirmed that the right to health is a basic human right to which they are entitled. They presented their concerns and initiatives for better health, including traditional and indigenous approaches.

A small selection of these stories and testimonies from different parts of the world are presented here. They illustrate current problems and innovative solutions as people struggle to improve their own and their communities' health. The stories demonstrate how common and critical problems at the local level are influenced or

determined by policies or decisions made at the national and international level. The stories enable links to be made between the everyday realities of people, policy-making and global politics which can in turn strengthen policy development at the local, national, regional and international levels.

These stories illustrate a variety of experiences involving health and health-related sectors: innovative, community-based health care initiatives; intersectoral responses to environmental problems; and organised actions or movements to address major economic and social threats to health. They describe people's direct experiences of health and health-related problems, their own analysis of causal factors, their initiatives, their successes, failures and proposals for the future.

As far as possible, these stories and testimonies have not been edited beyond clarifications of translations and insertion of punctuation. They are prefaced with comments made at the Assembly on the relevant topic or extracts from background papers prepared for the Assembly (available at website: www.phamovement.org)

Health, Life and Well-Being: South, West, North and East

Solidarity with people resisting globalisation was the main theme of the first day of the Assembly. Globalisation, as practised by companies and international institutions, is taking away people's right to health, said Violeta Menjivar from El Salvador. "Let us globalise our experiences and our vision and develop a current of human solidarity so that we have equity and justice in health," she said.

Govinda Pillay, a long-standing member of the legislative assembly in the southern Indian state of Kerala, explained that the major improvements in health in Kerala had come about "through mobilisation of the masses at the grassroots level". But he noted that Kerala's gains, which are praised throughout the world, were under threat from cuts in government funding for services such as health care because of pressure from international financial institutions.

"The new processes of globalisation, liberalisation and privatisation have tolled the death knell of Health For All," said N.H. Antia from India. "It will also be the death knell of the planet if we don't take adequate corrective measures at this stage". As public funding for healthcare has been reduced and as healthcare has been turned into a business, "'Health For All' is becoming 'Death For All'" argued Vilma Salinas of the Philippines.

Cost Recovery Can Be Fatal

Mwajuma Saiddy Masaiganah
Tanzania

In Naikesi village in Songea, a pregnant woman went to the rural hospital. The Rural Medical Aid asked her for a fee. Although this was very little, it was a great deal for the woman and she did not have the money. The Rural Medical Aid turned her away, saying they were not allowed to treat anyone without payment.

The woman went home where both she and her unborn child died.

In fact, there was provision in the policy for payment to be waived for pregnant women and children, but the communication had not reached the Rural Medical Aid. As is so often the case, neither the woman nor the rural community were aware of their rights.

To date, there is still a gap between communities and the government in the practice of national policies. For example, in the health sector, although there is the will and intention to improve the health system, considerable communication barriers remain between policy makers and the poor communities.

There are considerable communication barriers between policy makers and poor communities.

The cost sharing exercise in the health delivery system requires people to contribute towards services they receive. It is not that people are not willing to contribute if and when communication has been made with proper information on why, what and how the procedures are made or to be followed in implementation of the system.

But rather the communication barrier that exists denies the communities a right to contribute to the implementation of the process, which leads to inefficiency and ineffectiveness of the system and hence the negative impacts on people's lives.

In this case, a pregnant mother and her expected child lost their lives just because she did not know that expectant mothers and children are not supposed to contribute to hospital services. At the same time, the Rural Medical Aid did not understand properly the cost recovery guidelines, hence turning away the woman who went back to her death.

This story is not only about the death of a pregnant woman and her unborn child because of the cost recovery policy. It is also about the failure of "safety net" policies which target the poor, the lack of proper communication channels between policy makers and communities, and the lack of awareness among the woman, her husband, villagers, health staff and communities of their entitlements and rights.

The Story of Noemi

Geovanni Atarihuana
Ecuador

Noemi was twenty-five years old and lived in the rural area of southern Ecuador. It was her first pregnancy and she was very happy. She went for routine blood tests, prenatal medical care, and had an ultrasound examination at thirty-seven weeks. She took vitamins and had the vaccinations suggested by her doctor. It was an uneventful pregnancy, and her excitement about the new baby grew day by day.

It was during the second shift, at about two o'clock in the afternoon when Noemi arrived at the emergency room of the community hospital with frequent and continual pains in her abdomen. At the initial review, the resident doctor diagnosed a normal delivery and Noemi was sent to the obstetrics ward. About three or four hours after her arrival, Noemi was ready to give birth and was sent to the delivery room.

Noemi and her son became part of the mortality statistics.

After a few minutes, the contractions became less intense and less frequent and the uterine activity became quite irregular. The medical resident began giving her treatment to stimulate contractions but this did not improve her deteriorating condition. Two hours passed. When the situation did not improve, it was decided that Noemi be transferred to the provincial capital two hours away.

Noemi was exhausted when she arrived in the company of her desperate relatives. She was tired and in agonising pain. She was examined and it was decided to perform an emergency Caesarean section. She entered the operating theatre never to leave alive, neither she nor her son. Her unborn son had already died and Noemi died during the operation.

Noemi and her son became part of the statistics, part of the maternal and perinatal mortality rates. In Ecuador, maternal mortality has reached rates of 160 deaths per 100,000 births. In some rural areas, it is 300 or more per

100,000 live births. Just thinking of the numbers leaves us quite cold, but knowing the history of Noemi leaves us with a bitter sensation which is difficult to accept. Noemi ought not to have died.

Alone and Frightened

Sarah Burns
United Kingdom

I have listened to the stories about people dying because of poverty. In the UK, people have access to doctors and medicine but are still alone and frightened. I work with Susan who is in her mid-50s, is losing the use of her arms and legs, and is a wheelchair user. Her children never see her. Susan is lonely and depressed and she can't get out of her home. Her neighbours didn't help. Medicines didn't help, and one New Year's Eve, Susan tried to kill herself.

To feel needed is vital to health and to feeling human.

What could her doctor do? Susan's doctor wanted to develop a new way to prescribe the care and love that people so often need – but can't buy with money, even if they had it. Because I was already trying to help Susan, we decided to develop a new scheme called a Time Bank. Members of the Time Bank give their time doing what they love to do and get their time back from others when they need help themselves. Everybody's time is equal – whoever they are.

As well as helping Susan get what she needs, the Time Bank has helped her to feel needed. And what I have learned is that to feel needed is also vital to health and to feeling human.

Lipi's Story*

Bangladesh

I have returned to this filthy world leaving my cruel, beloved man. But still it is the safest place for me. I eloped

*Lipi is a pseudonym.

with "my man" just a few days after the death of my friend, Nargis. She was my best friend. She used to smoke and was addicted to marijuana and alcohol. Everybody, from a five-year old child to the oldest one, smokes here.

Nargis was a child prostitute. At Doulatdia brothel, more than 30% of the girls are less than 15 years old. Girls are malnourished and thin. They take tablets to look plump, tablets which are meant to increase the amount of milk cows produce.

Religious leaders would not offer any funeral prayers for a prostitute.

Nargis's woes started when she became pregnant when she was just over 14 years old. Once, we were the campaigners and promoters of the use of condoms; but when a prostitute meets her "man", she seldom uses any condoms. There are also some rich customers who do not like to use condoms.

I advised Nargis not to receive any customers at this stage. But, like other poor girls, she had no savings which she could survive on and so she continued to work.

Soft rice and fish-curry were the favourite food of Nargis. Like 60% of the prostitutes at Doulatdia, Nargis used to buy rice, fish and curry from the hawkers as, like others, she did not have any space for cooking, even no time to make food.

I can remember the day well. In the evening, our hawker sold pieces of big fish at a very cheap price. That day, we had seen how fishermen mixed poison in the logging water and caught fish. At night, I heard Nargis crying loudly. She was crying because of severe pain in her lower abdomen. It started to bleed.

Leaders of the Mukti Mohila Samity (an organisation of brothel women) took Nargis to the local government health clinic, but the doctor and the nurse refused to treat a prostitute. Then, the brothel women took her to a private clinic at the district town. Nargis died 30 minutes after reaching there.

The tragic drama began with her dead body. Religious leaders would not offer any funeral prayers for a prostitute and ordered that her body should not be buried. We

waited 'till midnight. We carried her dead body to the bank of the big river, the Padma. A bundle of bricks were tied to the corpse, and from a boat, it was thrown into the middle of the river.

After returning to our *para*, I made a firm decision to leave the cursed brothel, as I did not want to become a corpse like that of Nargis. I escaped, but my ill-fate compelled me to come back to this filthy place. There is no water-sealed latrine in the whole *para*. Every family uses a hanging latrine. A bad smell is always in the air. I use a handkerchief to cover my nose. Nargis used to say, "Yours is a princess's nose! Is this worse than that smell that comes from that acid-producing factory?"

"I earn the highest amount of money, but I did not want to be a sex worker."

I had to go back to such a situation. But I did not want to return. I did not want to earn money by becoming a prostitute. But for me that was another story. My mother's sex business had not been going well. She had borrowed money from many people and she had asked me again and again to be a sex worker. But I was adamant that I wouldn't. Some of my friends and development workers of KKS [Karmajibi Kalyan Sangstha or Welfare Organisation] had been supporting me.

It was the day before Eid-ul-Fitre [the main Muslim religious festival] in 1997. The development workers of KKS had left for the Eid vacation. That evening, we were joyous to see the moon of the Eid-ul-Fitre. Everybody started decorating her house. At 8 o'clock in the evening, my mother came to me with a beautiful *sari*. I was delighted. Soon, she began to ask me to go into the sex business. I simply answered, "No". Then she started shouting and crying. She caught hold of my feet and begged me to save the family from starvation. Again, I said, "No".

Suddenly, my mother put something in her mouth and cried out loudly, "Be happy to be a chaste one; but I shall die ..." I quickly realised what was going on, jumped on my mother and cried out, "Don't take poison, mother! I will obey you." Mother started vomiting and we, all her

children, started crying.

I ran to the KKS office, but nobody was there. I had forgotten that they were on holiday. I became very frustrated. Breaking all my promises, at the dawn of the Eid Day, I received a rich customer. I became what I did not want to be. I could not escape my destiny. Now I am 15 years old. I earn the highest amount of money of all the other prostitutes at Doulatdia, but I did not want to be a sex worker.

I am telling you again that I shall not be here for much longer. I shall escape again. Now, I am waiting for my mother's return. Goalanda Thana Police arrested her under the Public Safety Act and sent her to jail although there was no allegation against her. On 10 July, the police raided and looted Doulatdia brothel supposedly to arrest miscreants. Forty sex workers were injured. We always try to satisfy the police but their demands are increasing day-by-day; they continuously harass our people.

Please pray for me and do something for us – the brothel children.

Health Care and Health Services

Health care services worldwide are often inaccessible, unaffordable, inequitably distributed and inappropriate in their emphasis and approach. Many of these problems have worsened over the past decade. Government expenditure devoted to local health services has been stagnant in developing countries and has decreased in developed countries, or is increasingly channelled towards the for-profit sector.

Public services in general, and health services in particular, have become increasingly starved of national resources, resulting in their deterioration and even collapse at all levels. Inadequate financial allocations for capital and recurrent costs have led to a decline in the quality of health care facilities, shortages of equipment, drugs and transport and deteriorating performance from health personnel.

Yet health care can also be a subtle yet widespread instrument of social control. The causes of illness are often attributed to ill-considered individual behaviour or misfortune, rather than to social injustice, economic inequality and oppressive political systems.

"They Said We Weren't Good Enough"

Alayna Watene

Aotearoa (New Zealand)

Some people say "I think, therefore I am". Others say, "I belong, therefore I am".

As the eldest *Mokopuna* (grandchild), my grandparents brought me up with a strong cultural identity and Maori values of *Aroha* (love), *Whanaungatanga* (strong family relationships), *Wairua* (spirituality) and *Whakapapa* (genealogy). As a child, I felt enveloped in love by *Whanay* (family), *Hapu* (sub-tribe) and *Iwi* (tribe). I believed and understood my own self-worth, grounded in my *Turangawaewae* (place to stand).

Many young Maori did not have this cultural nurturing. From the late 1950s to 1970s, 78% of the Maori people living on their *Turangawaewae* or ancestral land

moved to the cities as part of the assimilation programme. The sense of social cohesion – *Tukanga Maori* (values and principles), *Whanau* (family), *Hapu* (sub-tribe) and *Iwi* (tribe) – were lost for many Maori. The system that dominates New Zealand society was firmly planted in British history and education, even though Aotearoa (New Zealand) is in the South Pacific.

As a result of colonisation and mono-culturalism, my people, like many other suppressed peoples, have the worst health and social deprivation statistics in the developed world.

In the 1970s, the government acknowledged the treaty of Watangi as New Zealand's founding document. Many pieces of legislation incorporating the treaty of Watangi have been passed. The principles of partnership, protection and participation between the government (Crown) and Maori has added life to the Maori Renaissance. The catch cry for Maori development is *Tino Rangatiratanga* (self-determination). No longer do we accept "We're Not Good Enough" to manage and control our own health, education and economic development.

We can manage and control our own health, education and economic development.

Struggling against Caste Exclusion: Two Health Workers' Stories

Chinthamani and Abrurupam (translated by Hari John)
India

Chinthamani and Abrurupam are TBAs (traditional birth attendants) and are *dalits*. The village elders selected them to undergo training and hone their health skills to become village health workers (VHW) for their village. When they first came for training, they were very diffident and greatly lacked self-confidence. Being outcaste women with abusive husbands did not help the situation either. Both of them had learnt their skills from their mothers who themselves had learnt it from their mothers. When they first started coming to the trainings, they did not think that

their skills were important ones. All that they had got for their skills so far was physical abuse from their husbands who were not at all supportive of their work.

Both women have used their health skills to change power relations within the household and the community.

The two women came regularly for their training along with women from other villages. Here, they learnt sterile techniques for delivery and other simple health skills. The trainings concentrated on giving importance to what they already knew and strengthened their large repertoire of experiential knowledge. Slowly their confidence grew and they started believing that the skill of healing that they had was an important one. As their self-confidence grew, so did their confidence in dealing with their spouses. Their husbands are now very supportive and have also accepted household roles to help with the added responsibility of caring for the community.

One day, while the VHW training was taking place, a pregnant woman was carried into the hospital on a rope cot. This woman belonged to a high caste community. She had been travelling by bus on the bumpy village road and had gone into premature labour. The high caste midwife was brought to do the delivery. The first baby was born without any difficulty. Then, to the surprise of the midwife, a hand came out. Until then, neither the pregnant woman nor the midwife knew it was a twin pregnancy. The high caste midwife said she could do nothing and that the patient had to be taken to the hospital. The doctor examined the patient on arrival and diagnosed the second baby as being in a transverse position. The doctor needed general anaesthesia to perform a Caesarean section to remove the baby who had now died. The hospital did not have general anaesthesia and the doctor advised the family to take her to the district hospital which was 25 kilometres away. Chintha, who had come in for her monthly training, was present during this discussion. She told the doctor that she would like to try delivering the dead baby as she had done so four times before.

The doctor was in a dilemma as Chintha was an outcaste or *dalit* and the patient was a high caste woman.

If anything went wrong, Chintha would be held responsible and would be taken to task by the high caste community. Putting such doubts aside, the doctor decided to allow Chintha to attend to the patient. She watched with amazement at the skill and ease with which Chintha first pushed the baby's hand back into the uterus by massaging the baby's buttocks through the mother's rectal wall. She then delivered the dead baby without much trauma to the mother or cost to the family.

While Chintha is well-known for her expertise at complicated deliveries, Abrurupam is a pioneer in her village at standing up to the high caste people. She was the first person to raise her voice against caste discrimination such as not being allowed to go barefoot in front of a high caste person or having to fold one's hands and bow in front of them. Once, when one of the high caste women was having a difficult labour that could not be managed by their own caste midwife, they called Abrurupam as a last resort. They wanted her to come through the back entrance and deliver the baby in the cowshed. Abrurupam strongly objected and insisted that she would come only through the front door and deliver the baby in the house. They were forced to accept her terms and, to top it all, Abrurupam gave the baby its first bath at the entrance of the house in full view of the whole village. This was a turning point in caste relations in the village.

Both Chintha and Abrurupam have been able to use their traditional health skills to change power relations both within the household and within the community.

The Palauan Parable of Natural Birth: A Story of Knowledge and Generosity

Robert Bishop
The Democratic Republic of Palau, Oceania

Some 2,000 years before the WorldWideWeb, the Palauan knew of the potential of connecting people and knowledge through a web.

In the times of the misty past, spiders lived separate

from people. Their lives were difficult as they and their webs were blown about by the winds. One day, a kind-hearted man noticed the plight of a spider in a tree. He asked the spider to build his web in the safety of the porch of his house. The spider agreed.

Several days passed. The spider called over the man. As the man approached, he noticed the spider taking down and folding his web. The man asked "Are you leaving?" The spider answered, "No, I am just securing my web because a typhoon is coming." So the man thanked the spider for the advance warning and secured his home.

The man's wife was pregnant. It was the custom in those days to cut open the mother to deliver the baby because natural childbirth was unknown. Being kind-hearted, the man did not want his wife to suffer this fate.

Knowledge may come from the most unlikely sources.

One day, it dawned on him that, since the spider had knowledge much beyond others, perhaps the spider knew how to keep both the mother and child in good health. He asked the spider if he knew a better way. The spider answered, "As you have shared your home with me, I will share my knowledge with you. I will guide you through the better way when the time comes."

On the day of the full moon, the wife went into labour. The man kicked out the midwives and brought in the spider. The people thought he was raving mad. With the help of the spider, a bouncing baby boy was soon born, as was the knowledge of natural childbirth.

Please ponder this:

- Knowledge may come from the most unlikely sources.
- Shared knowledge betters the life of all participating in the sharing.
- Kind heartedness and generosity leads to wisdom; wisdom in turn nurtures greater and better knowledge.

An ancient proverb: Knowledge is the most powerful and valuable when fresh. It is like a hot rock. If we choose to hide it by swallowing it, it will burn a hole in our stomach. But if we choose to share it and pass it on, it will pass through many hands quickly, warming all those that share it.

Inequality, Poverty and Health

Inequalities between and within countries have widened sharply over the last two decades. While a small number of people are becoming increasingly wealthier, the majority, including the poor in richer countries, have to contend with increasing unemployment, loss of assets and deprivation. More than a quarter of the 4.5 billion people in developing countries do not survive beyond the age of 40 years old.

At the People's Health Assembly, a village health worker from Nepal enacted the plight of a young woman who was typical of many she worked with in villages. The woman was in bonded labour and had no food or money. Her husband had died. To ensure her child was fed, she felt she would have to offer her into bonded labour. How could she put her daughter through the misery that she herself had faced all her life? Her final cry was "God help me or let me die."

Thelma Narayan from India pointed out that this story reflects the situation of millions of women in Asia and highlights the gender inequality of poverty and ill health. "It is the suffering that moves us," she said. "Our anger at the injustice has led us to develop strategies to cope. What we are recognising is that this is a global phenomenon and therefore the response needs to be global. We need to address the issue of power and to look at how power affects the lives of people."

James Orbinski of Medicins Sans Frontieres (Doctors Without Borders) said that poverty and injustice are about people's lack of liberty. We need, he said, "to use our liberty and use our voice to improve the lives of all". He pointed out that international finance institutions such as the World Bank and the International Monetary Fund (IMF) have co-opted the poor and the language of the poor. "We must stop this co-option and define our own clear vision sense of action and voice."

Irene Fisher from Australia noted that the various presentations enabled her to see how other people are coping with health issues, which have common root causes around the world.

Jawoyn

Irene Fisher
Australia

Jawoyn means language, people and country. Knowing our country is not a matter of drawing lines on a map. Owning Jawoyn country is through connections to sacred sites, through Jawoyn descent and from knowledge of our lands, law and ceremonies. Jawoyn-ness comes from the land to its people. We have collective ownership of language and responsibility for country.

The Jawoyn people traditionally occupied an area of about 34,000 square kilometres in a region called the Northern Territory of Australia. The region is sub-tropical and has two seasons – a "wet" and "dry". The monsoons come down from the North and drench the landscape in December through to March, followed by six months where almost no rain falls at all. This has significant implications for the type of diseases prevalent in the area and the level and quality of health services delivered on the ground.

Before contact with white people, Jawoyn people enjoyed a flourishing civilisation dominated by a rich and dynamic culture. Strong ceremonial ties were maintained with surrounding Aboriginal nations – these connections continue today.

Contact with Europeans commenced sporadically in the late nineteenth century, firstly with explorers and then with pastoralists and miners searching for riches and prosperity. As with other areas in Northern and Central Australia, much of the early contact was characterized by brutality, including massacres and rape. This "invasion" by outsiders was accompanied by the introduction of diseases to which the Jawoyn had little or no immunity, and by disruption to the local subsistence economy, particularly in pastoral areas, where Jawoyn people were forced away from traditional hunting and fishing areas.

At the same time, there was a cascade of regional destruction of bush foods and environmental damage as hard-hoofed animals such as cattle and water buffaloes

were introduced. The effects on the health of our people were immediate and devastating.

From the 1930s, horticultural activities occupied the rich river flats along the Katherine region – at a time when these areas were still being used as ceremonial and burial grounds. It was around this time that Aboriginal people were moved away from the township areas of Katherine, and the first fringe camps were established.

Gold mining dramatically reduced the numbers of Aborginal people in the region.

Mining came to the region with the Pine Creek gold rush of late last century. It has been estimated that this alone led to a dramatic reduction in the numbers of Aboriginal people in the region. This process continued to the 1950s, accelerated by the events of the Second World War when hundreds of Aboriginal people were forced into camps by the army. Jawoyn people, along with many other groups, worked for the army during the war. For many, this was the first time that they were paid money for their labour. This is all in the memory of our people living today.

In the 1950s, uranium miners came into the northern areas of Jawoyn land. This not only led to severe – and continuing – damage to our country, but also led to illness among the Jawoyn community as sacred sites were disturbed and damage. Until the 1950s Katherine was still a small town – less than 1,000 people. But it was a town in which Aboriginal people were not welcome. There was a curfew for all but a few Aboriginal people; many lived in bush camps scattered on the edge of town; many more had been herded into government settlements such as Tandangal and Beswick. From this time, government control over peoples' lives was intensified. It was from this period that utilisation of bush tucker [food] began to decline, and the dependence on introduced Western foods began to intensify. Aboriginal people had no independence – we were regarded as "wards of the state".

Uranium mining continued damaging our country and causing illness.

From the 1960s, legislative and social changes led to

the introduction of legal drinking for Aboriginal people. Within a short period, many of our people began to adopt the binge drinking habits of white stockmen, and alcoholism began to infiltrate our communities. All of this is in the memories – and experience – of people alive today.

Looking around the Aboriginal communities of the region, the legacy of ill-health experienced by our people is a stark reminder of a continuing history. We have a life expectancy 20 years less than non-indigenous Australians. Although the infant mortality rate has declined, it is still three times the national average.

Representing our nation, the Jawoyn Association was established in 1985 to give us contemporary political, social and economic influence over our traditional land. Since its formation, the Jawoyn Association has found themselves increasingly at the cold face of dealing with primary health issues, social issues, chronic diseases, acute hospitalisations and youth suicides. It has taken us three years to obtain any government funding for health. This has enabled us to expand our services to include more recreational activities that allow for old people to teach the young "out bush" where it should be taught.

The legacy of ill-health of Aboriginal communities is a stark reminder of a continuing history.

Last year, our elders participated in a major project to implement traditional fire/land management practices throughout Arnhem land. The West Arnhem Fire Management project aims to put traditional land management practices back into action. By taking people on bush camping trips to conduct fire management, we enable people to spend time in their traditional country. It also encourages knowledge of and pride in traditional ways. Elders can teach younger people the stories and show them where the sites are. This is an important part of maintaining cultural heritage and passing on traditional ecological knowledge. The strength and pride that older people draw from being on their country and teaching others about it is inspirational. It is not just about encouraging physical activity: it's about keeping

our culture "alive" and maintaining our responsibility to the land.

The most important criterion for sustained change is community control of health.

Some 15 months ago, we began discussions with the Fred Hollows Foundation to identify a project that could improve indigenous health. From our food program, we knew that there was real hunger being experienced in the communities, particularly amongst the children and elderly. We also knew that the majority of chronic diseases were related to lifestyle problems, so we decided to tackle the issue of community nutrition. Both organisations realised that if we were to bring about sustainable change, it was going to be an enormous task that required long-term commitment. It was not enough to say, "okay, let's employ a nutritionist and educate people about healthy foods." It would also be too simplistic to suggest that alcohol and substance abuse were the sole factors.

The Jawoyn over the last decade or so has been actively working to rebuild itself as a nation. In part, this has been a political battle. The Land Right Act of 1976 allowed some of our traditional lands to come back to us in 1977. Since the 1980s, we have called this land the "Jawoyn nation". Successive waves of migration to our country mean Jawoyn now comprise less than one-fifth of those living in Jawoyn land.

We have also engaged in an economic battle. The chronic unemployment of Aboriginal people in the region has led to our involvement with economic enterprises such as boat and canoe tours.

But it is also a social battle to rebuild our communities and families. It is for this reason that health figures as a central part of the work we must do. Mortality rates are not just statistics: to us, they're family. The physical, cultural and spiritual costs are enormous. The establishment of the Nyrrany Tribal Health Board is part of the process by which the Jawoyn Association and the communities of the region begin "rolling back" this history and take control over all aspects of what happens on our lands.

If our recent funding submission is successful, the Board will take control over all the health services currently being provided to Jawoyn communities by the Northern Territory government. Successive government-run health facilities have collectively failed to provide adequate health services to Aboriginal people living on Jawoyn lands. In our proposal, we will maintain the provision of acute medical services as well as provide new services directed at the management of chronic illness such as diabetes, hypertension and heart disease. Maternal and child health will also be a priority.

Through the development of these services, it is expected that acute episodes of illness will decline, resulting in fewer resources necessary for acute care in the community as well as a decline in hospitalisation rates.

We suspected that the barriers to good nutrition were more than lack of nutritional knowledge or substance abuse, that there were socio-economic and cultural factors that impacted on it. Consequently, the first priority in this project was to identify those barriers and our first task was to commission a scoping study of the communities on Jawoyn land. The purpose of the study was to identify barriers to achieving improvements in nutrition and to assess the current capacity to monitor health impacts that may result from the implementation of our project. In order to make sustainable changes in health, it is important to address the underlying social, economic and environmental factors that impact on it.

But perhaps the most important criterion for sustained change is community control of health. It needs to be driven by the people who have the most vested interests in its success.

A Tale of Saleha

Saleha Begum

Bangladesh

Saleha was a member of the Sunflower Child Council of Gopalpur Upazila in Tangail District. She was a good

student of Class VII and could recite all the Sections of the UN Convention on the Rights of the Child, but she used to say, "When shall we achieve all the rights?"

Saleha's eldest sister was married at 14 years old. She died while giving birth to a child at the age of 15. Her father is a sharecropper and her mother is a worker in a *bidi* [tobacco] factory. Her younger brother, Rashid, is also a labourer at the *bidi* factory. Rashid, who is 13 years old, is disabled. He broke both legs by falling from a betel nut tree when a rich family hired him to harvest betel nuts.

Once Saleha had diarrhoea. She took Oral Rehydration Solution regularly for two days but was not cured. A villager advised her family to give Saleha Pepsi Cola, a beverage drink that would cure diarrhoea. Saleha's father sold three green coconuts and bought a bottle of Pepsi. But after drinking the Pepsi, Saleha started crying as she felt severe pain in her stomach. She was hospitalised immediately. But the necessary medicines were not available there. The physicians said that Saleha had been suffering from malnutrition, so she should be given nutritious food.

Children, especially girls, are often malnourished because of discrimination in distributing nutritious food.

Then Saleha's mother became ill from working too hard. This time, Saleha did everything for her family. Before going to school, she fetched drinking water from the tube well, washed utensils in the canal, cooked food and fed everybody. One day, she went to a Fakir's house to bring water purified by sacred text. A villager met her on the way and chose her as a bride for his son.

Rafique was a student of Class VIII in the same school where Saleha studied. In co-educational schools in Tangail, the girl students go out of the class with the teacher when class ends and wait in the girls' common room to accompany the next teacher to lead them to the next class. Saleha saw Rafique several times but never talked to him. In 1999, while the members of 1,400 Child Councils of Tangail district were observing Child Rights Week, Saleha and Rafique got married.

Immediately after the wedding, Saleha stopped going to school and went to her father-in-law's house. Being a married boy, Rafique used to feel shy at school and he started to miss classes. For this reason, his father used to rebuke Rafique in abusive terms, and teachers at school used to beat him in the class. During the night, Saleha massaged oil on Rafique's back and thought, "How cruel the elder people are!" Ultimately Rafique stopped going to school but his angry father did not stop abusing him, even in front of Saleha and Saleha's father. The boy became so upset that one day he drank pesticide. He was taken to the hospital. Before his death, he embraced his father and said, "I did not want to die, father! I just wanted to frighten you. Please don't beat me any more".

Legislation has been ineffective in prevent early marriage for girls.

After the death of her husband, Saleha started wearing the customary white sari which is a symbol of widowhood. She was soon sent back to her father's house. The leaders of the Sunflower Child Council were able to convince Saleha's father to send her back to school. In August 2000, Saleha was married again to a *bidi* trader who is 30 years old and has another wife with two children.

This story illustrates several problems. There are often inadequate health services for children. Children's access to medical treatment needs to be increased at both government and non-government level.

Children, especially girls, are oppressed in various ways in society. Children are physically punished or tortured within the family, at school and especially at the *madrasa* (religious school). Early marriage for girls is on the increase; legislation has proved ineffective in preventing it. Children often suffer from malnutrition, girls in particular, because of discrimination in distributing nutritious food.

Child labour is risky and hazardous. Recruitment of child labourers for factories and other hazardous jobs should be stopped as soon as possible. Children already in such work should be rehabilitated into less labour intensive jobs.

Environment and Survival

Drastic environmental problems such as the changing climate and the depletion of the ozone layer are likely to hurt the poor and marginalised first. Indeed, there is as much environmental injustice around the world as there is social injustice. Environmental and social injustices often have similar patterns of distribution, origins and detrimental affects on people's health. These injustices are closely interrelated and often reinforce each other.

Canadian anti-nuclear campaigner Rosalie Bertell highlighted the role of the military in acting as a protector of overseas investment. "The military is the real strength behind the multinationals," she said. The arms race, and nuclear testing in particular, are having an extremely harmful effect on global ecology.

Health and Petroleum in the Amazon

Geovanni Atarihuana

Ecuador

Petroleum is, and has been, for Ecuador, besides a main source of income, a cause of destruction of the environment. Since 1972, international petroleum companies led by Texaco in collaboration with the government company, Petroecuador, have extracted more than two billion barrels of petroleum, mostly from the Amazon. In the process, billions of gallons of petroleum and toxic waste have been thrown into the environment.

In 1993, a group of indigenous peoples and peasants from the Amazon, representing 30,000 affected persons, presented in New York a demand against Texaco accusing them of irreversible damage to the environment.

In 1994, the Amazonian Defense Front (FDA) was created with the participation of many indigenous and peasant organizations and with the objective of supervising the legal case against Texaco. Since its foundation, the FDA has organised several workshops on the environment, reports on spills, denouncements and

community meetings for sharing information. As a result of these experiences, the Network for Monitoring the Environment of the Ecuadorian Amazon (RMA) was created which included numerous local and national non-governmental organisations.

In 1994, the Center for Social and Economical Rights published a report about dangerous levels of petroleum contamination in the northeastern rivers of Ecuador. It found high concentrations of polycyclic aromatic hydrocarbons in drinking, bathing and fishing waters. These contamination levels are 10 to 10,000 times higher than the limits permitted by the United States Environment Protection Agency.

Levels of petroleum contamination in Ecuador are 10 to 10,000 times higher than US limits.

In 1998, the RMA asked Manuel Amunarriz of the Epidemiology and Community Health Institute to help determine the impact of petroleum contamination on the health of their communities. This study called the Yana Curi Report – *Black Gold in Quichua* – found that the women of communities next to the petroleum wells and stations had a higher incidence of having irritation of the nose and eyes, headaches and sore throats, diarrhoea, gastritis, fungus and tiredness than the women from communities where there was no petroleum contamination. The incidence of these same women having spontaneous abortions was 150% higher than women who did not live in contaminated communities. Additionally, the populations with a long history of petroleum contamination had a greater risk of having cancer and dying from it than non-exposed people.

The communities affected, the RMA and environment groups from Ecuador are using this study to back up their demands about petroleum contamination and the terrible health problems it causes. Even the lawyers in the legal case against Texaco are using the study as proof before the judges in the United States. Nevertheless, any change in attitude of the petroleum company and the government concerning the environment of the Amazon and the populations that live there has yet to be seen.

27 years Defending the Health and Ecology of Our Island

Maria Ivania Cesar de Oliveira and Ani Wihbey
Brazil

We, the São Luís delegation form Maranhão, present our denouncements before you as we deplore the injustices committed against peoples excluded from society's mainstream because of sophisticated social, political and economic structures. "Health For All" is not a reality in today's world.

"Health For All" is not a reality in today's world.

1. We protest against the interference, exploitation and domination of the United States of America in poor countries of the world. In particular, we deplore the imposition of foreign projects in Brazil that completely disregard any respect for our citizens, our culture, our environment and our health.

2. We protest against the new pre-commercial agreement of April 2000 between the governments of Brazil and the United States of America allowing for the commercial exploitation of the Brazilian space base, situated in the municipality of Alcântara in the state of Maranhão. It is a target of international interest that threatens the autonomy, liberty and health of the Brazilian people.

3. We protest against the systematic reduction of the rural area and the decline of the health status in Alcântara, caused by the construction of the space base which began in 1986. This area sustained a population of nearly 25,000 people in 26 large communities. The vast majority of these people are Quilombos, descendants of the Tapuias Indians.

4. We protest against the implant of [US aluminium company] Alcoa's industries on the tropical island of São Luís in the state of Maranhão since 1980 which brutally deforested the green area including marsh lands which, under Brazilian law, are permanent preservation areas.

In so doing, a population of approximately 15,000 people from 10 communities who were sustained in this area by fishing, abundant fruits and home farming where heartlessly rooted from their natural environment and dislocated into non-fertile areas. The takeover of this land from the initial 3,500 to 10,000 people not only caused an elevation of the island's temperature but also created chemical pollution from chimneys and contamination of waters with bauxite residue (red mud) that promoted a return of some illnesses which had been controlled before.

5. We protest against the imposed domination policies of the World Bank and the International Monetary Fund with its demands of structural adjustment programmes that force the Brazilian government into privatising public services, including hospitals, and state enterprises, thus depriving people from their rights to these services as citizens.

6. We protest against all types of racial discrimination. As conscientious health educators, we call for a recognition of the dignity of all peoples and an end of silencing and suffocating a people because of their colour.

The Continuing Struggle of Bhopal

Sathyamala C.
India

At the outset, I must state that I am not one of those affected by the gas leak disaster. I have worked with the survivors as a medical researcher supporting their struggle for justice.

The actors in this drama are the Union Carbide Corporation (UCC, a US multinational), Union Carbide India Limited (UCC's Indian subsidiary), the Indian government, the Supreme Court of India and the people who, in December 1984, lived in Bhopal, the capital city of Madhya Pradesh in Central India.

The story begins not so long ago, in fact just sixteen years ago . . .

It was a night in early December. It was a night like any other. Windows and doors were shut right against the chill. The entire city huddled in deep sleep. Well, not quite. For, in a pesticide factory across the road, there was panic as workers working in the night shift watched with growing horror as a huge underground steel tank burst through the concrete floor and spewed its deadly contents into the night air. Since all the safety systems had been dismantled or were in a state of disruption, the 40 tons of deadly gases moved, unhampered, downwind to hang over the city for the next seven hours.

As the vapours entered the homes of the poor people through the cracks in the doors, holes in the walls or the gaps in the roof where a missing tile had not been replaced, a pungent smell of burning chillies and peppers filled the air.

Couples woke up coughing, spluttering, eyes burning, throats choking. Stumbling from their beds, they threw open their doors for a breath of fresh air only to be assaulted by the poisonous fumes waiting outside. Soon the air was rent with the screaming and wailing of hundreds of people as a nameless dread took hold of them.

Moving through the dead and dying, little did the people of Bhopal know that their misery was only just beginning.

Those who could got on to a bicycle or a rickshaw. Those who could not ran a race for their lives, downwind, where they thought security lay. Men who ran faster breathed harder and collapsed earlier. Whole families sleeping on the pavements of roads or on railway platforms were wiped out in one fell blow.

Did I say it was a night like any other night? It was no longer a night like any other night. Death reaped a grim harvest that night. As the sun rose to shine dimly through the poisonous cloud on the morning of 3rd December, those still living staggered back to look for their own. Mothers who had abandoned their children knew that they would carry this guilt coiled tightly in the pit of their stomachs forever. Moving through the dead and the dying, the carcasses of cattle littering the streets, bewildered

and benumbed, little did the people of Bhopal know that their misery was only just beginning.

Soon the hospitals were inundated as the patients looked in vain for a treatment that did not seem to exist.

The next few years saw the damage wreaked on the human body. Every bodily system – respiratory, gastro-intestinal, muscular-skeletal, reproductive, eyes and immune – began to manifest progressive irreversible damage. People began to age prematurely. Psychiatric morbidity began to rise. Death continued to stalk the slums of Bhopal with a determined deliberateness.

A health system unable to cope with the enormous numbers of constantly ill people and with the complex nature of their injuries began to blame the survivors. They were called malingerers and a new term, "compensation neurosis", was coined to dismiss their distress and suffering.

With no more tears to shed, with a grief too deep to mourn, people continued with the necessary task of living. While no one wanted to own up and take responsibility, the Indian government was only too willing to appropriate the rights of the survivors to litigate. And not just that. The Indian government, through its agency of research, the Indian Council of Medical Research, appropriated the right to medical information about the bodies of the gas-affected people. Information gathered through medical research was under the Official Secrets Act.

The only recourse left for the gas victims was to organise and demand their right for medical relief, compensation and justice. But every attempt to raise these issues was met with ruthless opposition. Peaceful demonstrations were disrupted by the police, demonstrators were beaten up, and their leaders labelled as terrorists and jailed on serious charges such as "attempt to murder".

Siding with the US multinational, UCC, the Indian government, on behalf of the victims, signed a settlement for a pittance. What was, in effect, on out-of-court settlement was blessed by the Indian Supreme Court as a full and final settlement against all future claims. The rights of children yet to be born were thus quashed.

In a twist of irony, if any new claims come up in future, it will be the Indian government that will have to defend the right of UCC. The settlement was a complete sell-out.

UCC did not have to pay out a single cent more than its insurance coverage. Compensation to individuals ranged from US$5,000 for deaths to US$500 for injuries. Life in India was indeed cheap.

More that 10,000 people were killed in the disaster and more that 200,000 were injured permanently. Yet all criminal cases against the culprits have been dismissed. In effect, the Indian Supreme Court's judgement appears to favour "the hand of God", not a greedy, immoral, US multinational, as the cause of the disaster.

The people of Bhopal, however, have not given up. They know that truth is on their side. Yet they know they will have to fight and struggle every inch of their way. They know their lives have been destroyed forever. They know their children's lives have been destroyed forever. And who knows, perhaps the lives of their children's children as well. They know that, in a world which is owned by multinationals and ruled by money, dialogue does not work. For them, Warren Anderson, the new UCC chief, is an absconder and a fugitive from justice. They are demanding that he be extradited and tried for the murder of 10,000 people and suffering of several generations. There is no room for dialogue.

The people of Bhopal have become seasoned fighters with women in the forefront of their struggle.

The people of Bhopal have become seasoned fighters with the women in the forefront of the struggle. They have nothing to lose and very little to gain for themselves. But they continue to struggle with their supporters, within and outside the country, for a better world so that their suffering may not have been in vain. Their struggle is our struggle, the struggle of all people all over the world whose lives are being poisoned slowly and not so slowly by transnational capital. This is not the story of one. This is the story of hundreds of thousands of people. I cannot end the story here because the struggle continues . . .

Floods and Life: A Case Study of River Erosion

Halima Begum
Bangladesh

I am Halima Begum. My husband was the late Harun-or-Rashid of the village of Chorkathi, PO Gabkhan, *thana* (district) Jhalkathi, [south Bengal]. My father, Monsur Ali Howlader, was a day labourer.

We were seven in the family, including my five sisters and brothers, and mother, and used to pass our days in utter hardship with the wage earned by my father.

But 15 years back, a catastrophe struck our family on the river Sugandha. One day, in the dead of night, the river engulfed our thatched cottage and homestead, and us all. We raised a hue and cry for help, and our neighbours saved us from would have been a catastrophic journey. But we were not saved from life struggle.

In the dead of night, the river engulfed our cottage and homestead and us all.

My father encountered great hardship along with us and was compelled to take shelter by the wayside under the blue sky without any food, clothing or shelter. Our life became extremely miserable.

Within some days, my father died of an unknown disease. After losing my father, we, the six members of our family, were attacked with diseases and grief. In such a situation, we were compelled to resort to begging.

When I was 7 years old, I got married. But my husband divorced me. Next I was married to Harun-or-Rashid of the village of Chorkathi, a kind-hearted day labourer. I was separated from my mother, sisters and brothers. My children and I had been living a very distressed life with my husband Harun.

One-and-a-half years ago, the river Sugandha again devoured my husband's homestead and assets. We became helpless like my father. My husband got sick and died on the last 28 June. I took shelter in a slum of the town. Now I am living an inhuman life with my five children.

Health Implications of International Policies

Three international organisations today have immense influence on people's health – and the World Health Organisation is not one of them. They are the World Bank, the International Monetary Fund (IMF) and the World Trade Organisation. The World Bank and IMF are shaping economic policies around the world. These neo-liberal policies are characterised by reducing the role of the state (privatisation) and increasing that of market forces (liberalisation). These financial institutions have pressured indebted Third World countries to implement various structural adjustment policies which have had profound social consequences and have directly affected people's health and access to health care. They have led to the collapse of weak and underfunded systems of public health even as they have increased levels of hunger and poverty and thus disease.

Describing the implications for health of the World Trade Organisation (WTO), Abdul Jalil, the Bangladeshi Minister of Commerce said that "our aim should be not only fair trade, but trade with a human face." He pointed out that one of the WTO's agreements, TRIPs, which governs so-called intellectual property such as patents, trademarks and copyright is "likely to have an adverse impact on public health programmes by making medicines costlier and unaffordable by the poor."

Mike Rowson of the UK NGO, Medact, criticised the way in which major public health issues are now being decided by international trade bodies such as the WTO. The WTO does not have any defined policy on public health, he said, but treats health just like any other service industry. The WTO's undemocratic approach, evidenced by trade disputes settled by trade administrators and lawyers behind closed doors, means that the concerns of the majority are ignored.

Dr Zafar Mirza of the Network for Consumer Protection in Pakistan said that the WTO's TRIPs agreement would continue to make many essential drugs unaffordable for the poor.

The stories and testimonies presented throughout the People's

Health Assembly bore witness to the impacts around the world of factory closures, civil servant layoffs, reduced commodity prices and debt repayments. As one voice from Central America said, "Illness and death every day anger us. Not because there are people who get sick or because there are people who die. We are angry because many illnesses and deaths have their roots in the economic and social policies that are imposed on us."

The Story of Joseph Kamombe and the Women's Quilt
Mary Sandasi
Zimbabwe

In 1990/1, Zimbabwe embarked on a structural adjustment programme. By 1992, some companies had closed down and laid off their work force. The people laid off were family men, and in most cases these companies could not afford to pay out any retrenchment packages. Some of the people laid off now had to live from hand to mouth. Many of those laid off went back to their rural homes where they had pieces of land for tilling. But those who remained in the cities and had no land to till joined the thousands who are the urban poor. They could no longer afford decent accommodation, good nutrition or treatment. Families were forced to share one or two rooms.

These problems continued year after year. The prices for food stuffs continued to rise and, out of frustration, in December 1998 the masses staged a demonstration which gave rise to food riots, during which shops were looted, and buses and cars were reduced to ashes. The riot police were outdone by the masses, and some of them were disarmed and made to have a taste of their own medicine. For the first time, the army joined the police to quell the disturbances. Armoured cars and helicopters were seen in the high density suburbs where the majority of the poor reside.

The cost of living went on rocketing. Important budgets that served the majority of the people, especially women and children, were cut. These were the budgets

for education and health. Because people had less food or could not afford nutritious food, their immunity to illness was reduced, fuelling epidemics like HIV infection, tuberculosis and sexually-transmitted diseases.

Joseph Kamombe had worked for a company that made blankets. He owned a four-roomed house, but three months after the retrenchment, his family rented out two rooms to other families to raise money, and in so doing created a problem of overcrowding. Their daughter, Esther, dropped out of school and became pregnant two years later. This family struggled to keep their bodies and souls together.

Later, Joseph contracted tuberculosis and, although he was on treatment, he could not eat well and died. His wife became very stressed, even more so when she was diagnosed as HIV-positive. She subsequently died of an AIDS-related illness. Esther, their daughter, was forced into commercial sex to provide for her brothers and is now herself terminally ill with AIDS. AIDS in Zimbabwe is killing about 2,000 people every week.

Women at the grassroots level began to make a quilt. They started in 1996 by taking headlines from the newspapers relating to issues that affected their health, embroidering them onto scraps of material, and making a large quilt out of the results.

The quilt-making women are writing a history of the policies that militate against their survival.

> "Cone textiles retrenches. Bread prices go up. Mealie meal goes up tomorrow. Bulwer hospital runs out of food. August 1996 the whole civil service is paralysed as nurses and all civil servants strike. Nurses and some doctors strike over poor working conditions and salaries destroying the health system which is already in a shambles. Milk goes up by 50%. Hospital faces closure."

One of the women of the quilt-making group died because she was unable to get into the hospital when complications arose during her delivery.

The women are writing a history of how they are being denied access to essential services by policies that

militate against their survival. They have been able to show how global forces that we think of as being out of our control have very human consequences.

Health Care Reform in Guatemala

Hugo Icu
Guatemala

I have the honour of sharing with you the process of health care reform in my country, Guatemala, that has been documented by the Association of Community Health Services (ASECSA), the national health network and civil society organisation that I represent.

My name is Hugo Icu, and I am a medical doctor of Mayan Kakchiquel origin. I come from Guatemala in Central America. Guatemala is a country of 11 million inhabitants where 70% of the population is indigenous and 30% are of mixed blood, descendants of the Spanish who colonised and dominated us for over 500 years. Guatemala is a multicultural and multilingual country, where there are 23 ethnic groups and 22 indigenous languages. But our official language is Spanish. The indigenous peoples maintain our own visions about life, the land, the universe and, of course, about health and illness. We have a rich traditional medicine with knowledge, practices and therapeutic resources maintained and passed on from generation to generation.

Indigenous peoples of Guatemala have a rich traditional medicine passed on from generation to generation.

In Guatemala, more than 60% of the population live in rural areas in conditions of extreme poverty. More than half of our people are unable to read or write. Our principal means of subsistence is agriculture, but the arable land is in the hands of a few, wealthy, land-owning families.

Some 45% of the population has no access to health services. The infant mortality rate is 190 deaths per 1,000 live births. The principal causes of infant mortality are diarrhoeal diseases, respiratory infections and malnutrition.

While trying to turn back these structural problems, we also lived at war for over 36 years. This left 150,000 people dead, 200,000 orphans and 60,000 widows.

Health care reform in Guatemala has been promoted since 1991 by advisers of the Interamerican Development Bank – IDB – and successive governments. But the real implementation began in 1997 after the signing of the Peace Accords. This reform is part of the tendency to modernise the state which is taking place over several years. It proposes a reordering of the health sector in which the roles and functions of the state, market and civil society are redefined. The objective is to privatise health care at the expense of the public health services. The IDB has been the most important financial institution in its strategic support of reform with its Program for the Improvement of the Health Services. It has determined the fundamental characteristics of the reform. These are based on the principles the World Bank put forth in its reports such as *Financing of the Health Services in the Developing Countries*, the *Agenda for Reform* (1997) and the 1993 *World Development Report: Investing in Health*. The guidelines for reform were outlined in the national 1996-2000 Health Policy of the government of President Arzu. The most relevant facts of this process are:

The objective of health care reform is to privatise health care at the expense of the public health services.

- A redefinition of the roles and functions of the Ministry of Health and Social Security with the private sector, both for-profit and not-for-profit.
- The approval of a new Health Code.
- The implementation of primary health care through the Integral System of Health Care (SIAS).

The SIAS is based on contracting private providers and administrators for health services. To function, they need only to demonstrate management capacities. For example, the SIAS has involved savings and loan co-operatives, a US petroleum company (BASIC) and cable TV enterprises. The population is divided into jurisdictions of

10,000 inhabitants, which are offered to private institutions. The services provided by the private entities are supposed to meet requirements determined in a vertical manner. This included the organisational model at the local level, the basic package of services and the budget per capita based on an average of $5 per person per year. The local organisational model requires the collaboration of a malaria worker and so-called health "guardian" for every 20 families. At the government level, it requires an institutional facilitator, an auxiliary nurse and an ambulatory doctor for each jurisdiction. In effect, the SIAS has generated a system that basically consists of voluntary personnel.

The problems that have been identified in the implementation of the Integral System of Health Care and the health care reform are:

Economic

- The provision of a limited, selective, low quality package of health services.
- The sustainability of the services depends on volunteers with heavy responsibilities. The health care of the poorest people depends on volunteer workers. If the volunteer fails, the system fails. In this way the government is able to maintain a low budget for the Ministry of Health, which historically has been about 1% of the GNP.

Cultural

- The rich experience of traditional resources and practices is not taken into account.
- The inspiration for the reform comes from other models such as those of Chile and Colombia.
- The implementation is in a vertical manner without consultation with the community and other health organisations.

Political

- With the increase in the commercialisation of health,

the economic sectors tend to dominate health policy decision-making.

- Privatisation results in the community making demands on private institutions, not on the state, which has the constitutional responsibility for health.

Social

- Various sectors of the population are marginalised and the services are inequitable.
- There is an incentive to introduce invasive and dangerous diagnostic practices.
- The doctor-patient relationship is destroyed.

We are faced with the dehumanisation of health, with the loss of the right to health, where what is valued is what you pay, where the solidarity and complementarity of our Mayan ancestors is substituted by individualism and competition. As the marketing of health services increases, it will be the external, negative, individualistic and egoistic values that will rule our health system.

The marketing norms of a globalised world sharpen the poverty and inequality of our peoples.

After the signing of the Peace Accords in 1996, the military war ended. Now we are facing a worse war, that of a globalised world with marketing norms which only sharpen the poverty and inequality of our peoples. The thrust for these changes comes from the influence the World Bank has exerted on our decision-makers. And the people have been left to pick up the pieces of a system that is flawed to our local realities.

Profits Before Rights

Fatema Akhter
Bangladesh

My name is Fatema Akhter. I am a garment worker. I work in a garment factory. As garment workers, we live and work

under difficult conditions but at least we are managing to earn a living.

Now we have heard rumours that in the next two to four years, the garment industry in Bangladesh may close down. What will happen to us? You are all perhaps aware of the situation of women in Bangladesh – women have very few opportunities for employment. We are, however, slowly making some progress. Because of jobs in the garment industry, many Fatemas like me are able to work honourably. "Garments" is the only option for us. We beg you not to take away these jobs and our right to work with dignity.

We garment workers are in constant terror of accidental fires.

It is not that our working conditions are very good, especially for us women workers. We have lots of problems like inadequate toilet facilities. In many factories, there is no lunch room so we have to eat under the open sky. Many of us have had to leave our small children at home, sometimes unattended. We want crèche facilities. Childcare facilities will relieve us of a lot of anxiety and in turn employers' shipments will not suffer,

I want to now remember with deep sadness those garment workers who were killed in a factory fire on last 25th November. We garment workers are in constant terror of fire incidents. We want all factories to have fire escapes so that there are no more accidents.

What Unemployment Means

Kevin Lafferty
United Kingdom

My story is the story of the unemployed working-class man of Glasgow, [a major town on the east coast of Scotland]. Glasgow has the worst health statistics in the UK, and an unemployment rate of 60% in the area I lived in. During the 1970s, new industrial centres and new housing schemes attracted men like my father, drawn by the belief and hope of providing a better life for their wives

and families. This was the first time that our family and many others would have an indoor toilet and separate bedrooms. There was hope and optimism.

Things changed, however, with shifts in the global job markets and the introduction of privatisation by the UK government. There were massive job cuts and redundancies. Men like my father who had been built up to be the breadwinners could no longer fulfil this role. Their skills were no longer required.

Unable to come to terms with this, many of the men turned to despair and eventually to drink and drugs. Risk-taking and violence were commonplace, and many women and children suffered greatly. Crime, alcohol and substance abuse, violence, ill-health and suicide. Unemployment leads to a loss of self worth and self-choice and alienation amongst these men who are left with no control of their lives. They gradually became an underclass. Many ended up homeless and alcoholics. Many more died way before their time.

Unemployment leads to a loss of self-worth, self-choice and alienation.

These problems go across two and three generations of men. My own nephew has never worked and his father has never worked. The proud, working-class man of Glasgow has been turned into an underclass who does not know what it is to work and who has no hope of working or getting a real job.

The promises made to my father and many others were false and the hope for a better life soon disappeared. These dreams were taken away by both the government and the World Trade Organisation. The working class men of Glasgow have been left to "Poke about in the ashes of their dreams".

Living in Remote Rural Australia

Marie Russell
Australia

I live with my husband Tom in the outback of New South Wales, 1,000 kilometres west of Sydney, on the banks of

Australia's longest river, the Darling River. We are wool farmers. We have six children between us, four of whom are married, and five granddaughters.

We live in the semi-arid rangelands of New South Wales, an area called the Western Division, which is equivalent in size to Pakistan, yet is home to only 50,000 people. The indigenous people of the land are called the Barcenji tribe and we co-exist in harmony. Reconciliation in Australia will come from the people, not from the government. My nearest town, Cobar, is 200 kilometres away, with a population of 6,000.

Rural women are the builders of social capital.

I would like to tell you about some of the real problems we face in remote areas of Australia and about my role in the community. I think it is very important that we encourage women to have a much greater voice in the decisions that affect our families, our communities and our environment. As in so many other countries, rural women are the major builders of social capital.

We have faced hard times in rural areas over the last ten years as a result of:

- low commodity prices after the crash in the price of wool in 1990;
- the long drought of the 1990s;
- escalating fuel costs (which are now crippling some industries);
- massive floods in the western part of New South Wales, causing devastation with stock and crop losses.

A lot of farmers will go bankrupt as a result of our floods, or have pressure applied from financial institutions. These farmers and their families have lived in the area for generations. A large percentage of them have endured long-term debt as a result of poor commodity prices forced by the worsening world trade climate.

Health

Declining medical services throughout rural Australia are having an impact on the community. In my area, we have a clinic, run by the Royal Flying Doctor Service, once a

month in our tiny village called Tilpa, which has a population of six people. There is always a nurse on board and a general practitioner (GP). This service is accessed by all the people in the district and other people passing through or working in the rural service industry, such as with the sheep shearing teams. People travel long distances to the clinic – up to 300 kilometres a round trip. This service has become more and more in demand over the last ten years as the economic downturn, the drought and the drought-breaking floods have all taken their toll on the community.

It can take up to three weeks to get an appointment with the GP in the town 200 kilometres away, so the Royal Flying Doctor Service is a preferred choice in our area. My husband and I have to travel only 50 kilometres each way if we wish to get prescription or have a check-up.

There is a need for physical, emotional and moral support for people to cope with challenging and changing circumstances.

Managing Change

Education for children in remote areas is becoming increasingly difficult; long separations of families have become a way of life. The women are leaving the properties and moving into nearby towns to educate the children and supplement farm income, returning only in school holidays, leaving the men to work in isolation and for long hours.

The health and well-being of the men is of great concern. Struggling families are being fragmented as they try to cope within declining economic circumstances and the restructuring of their industry. There is a need for physical support for men and their families as well as emotional, psychological and moral support to cope with challenging and changing circumstances.

There is rising level of suicide, with the problem concerning mainly men, particularly young men. It may only be the interest of women that in the long run will improve the health of rural men.

We have virtually lost a generation of children to the

regional towns or cities. Most of this generation will probably not return to the land. This is shown by the ageing of the farming population: the average age of farmers if 58 years.

From 1992 to 1996, there was restructuring in my area as the first wave of properties changed hands and old families left as result of the prolonged drought, high interest rates, low commodity prices, reduced stock numbers and rising costs. We are now seeing a second wave of people leaving – at a much greater rate. It has been estimated that 75% of the landholders in my area will leave the land within the next ten years. We are losing generations of expertise and knowledge and seeing absentee entrepreneur landholders buy the properties.

Women

Rural women are becoming more involved in decision-making and running the family farm. They are also becoming more involved in the decision-making process for the community.

It hasn't always been easy to achieve this, but women are now being more recognised than they were in the past and also more supported by their menfolk and the Federal and State Governments.

I am the Western Division representative of the Rural Women's Network, a state-wide programme which aims to provide an interface between government and the community to prioritise women's issues and to empower a diversity of rural women to achieve their own goals better. It is a network, linking with agencies, individuals and groups.

Who are rural women? There is no definitive rural woman. She may have lived on the land for 40 years or a mere four months. She may or may not speak English; she may be 18 or 80 years old; a single parent, wife or single woman; an employee, mother and/or indigenous. She may be a farmer or work off-farm. She may live in town or village or in the remote outback.

Some rural women live in the country by choice – for others, there is no other option. Incomes and conditions

all vary, but all are exasperated by the lack of transport, isolation and, in most cases, declining rural services.

I now participate in a number of other programmes in addition to the Rural Women's Network, such as Farming for the Future, which is assisting farmers to remain viable; the Rural Leadership programme, which is training women and men to take a greater leadership role in their communities, and Networking the Nation that enabled us to establish a cybercafe in a disused railway station in the town of Cobar.

I would like to finish by sharing a quote of Nelson Mandela's which I find very inspiring:

"Our biggest fear is not that we are inadequate,
Our deepest fear is that we are powerful beyond measure.
It is our own light, not our darkness that most frightens us.
We ask ourselves, 'who am I to be brilliant, gorgeous, talented and fabulous?'
Actually, who are you not to be? Your playing small does not serve the world.
There's nothing enlightened about shrinking so that other people won't feel insecure around you.
It's not just in some of us; it's in everyone.
And as we let our own light shine, we unconsciously give other people permission to do the same.
As we are liberated from our fear, our presence automatically liberates others."

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